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No. 92-1889

In The

Supreme Court of the United States

Supreme Court, U.S.
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October Term, 1992

BLUE CROSS AND BLUE SHIELD MUTUAL OF OHIO,

Petitioner,

vs.

LIBBEY-OWENS-FORD CO., AS ADMINISTRATOR OF THE GROUP HEALTH INSURANCE PLAN,

Respondent.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Sixth Circuit

RESPONDENT'S BRIEF IN OPPOSITION

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QUESTIONS PRESENTED

1. Whether a judgment of a district court dismissing all of the federal claims in the case with prejudice and on the merits is a final appealable order when the dismissal with prejudice was neither sought nor consented to by the plaintiff.

2. Whether a company that administers claims under an employee welfare benefit plan and has discretionary authority to construe the terms of the plan, to grant or deny claims, to resolve disputes respecting benefits, and to pay providers with funds provided on behalf of the plan is an ERISA fiduciary to the plan respecting its conduct.

3. Whether an ERISA fiduciary has a duty to account on demand to the plan for the matters and funds entrusted to it as common law fidicuaries are required to do.

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RESPONDENT'S BRIEF IN OPPOSITION

STATEMENT OF THE CASE

A. Introduction.

This is an ERISA action brought against Blue Cross and Blue Shield Mutual of Ohio ("Blue Cross") for claims arising out of its administration of an employee health care plan. The plan is self-insured and Blue Cross paid claims with funds advanced by the employer on behalf of the plan. It is now known that Blue Cross received refunds from hospitals respecting amounts paid under

the plan but did not refund or credit the plan for these refunds. The amount of these refunds is as yet unknown. There is also evidence that Blue Cross improperly paid nursing home claims that were not covered by the plan. The extent of improper payments is likewise unknown.

Respondent Libbey-Owens-Ford Co.[1] ("LOF") is the administrator and a named fiduciary of the plan and brought this action in its representative capacity for and on behalf of the plan for an accounting, for breach of fiduciary duties, and for restitution of amounts owed to the plan.

The district court held that Blue Cross was not an ERISA fiduciary and dismissed the ERISA claims and claims for common law breach of fiduciary duties with prejudice. The Court of Appeals reversed. It held that Blue Cross was an ERISA fiduciary based upon its discretionary authority as outlined in the specific provisions of the contract involved. The court also held, based upon the routine application of well-established principles of trust law, that Blue Cross had to account to the plan on demand for its conduct in administering claims. The case has been remanded to the district court for the accounting and further proceedings and is presently proceeding in that court.[2] The case is not yet complete

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1. Libbey-Owens-Ford Co. is a Delaware corporation with its principal place of business in Lucas County, Ohio. Eighty percent (80%) of the stock of Libbey-Owens-Ford Co. is owned by Pilkington Holdings Inc., which is not a publicly traded corporation. Pilkington Holdings Inc. is ultimately a wholly-owned subsidiary of Pilkington plc of the United Kingdom. Pilkington plc is publicly owned. Twenty percent (20%) of Libbey-Owens-Ford Co. is owned by NSG Holdings U.S.A. Inc., which is a wholly-owned subsidiary of Nippon Sheet Glass Company, Ltd. of Japan.

2. Blue Cross unsuccessfully sought a stay of the mandate from the Court of Appeals. It then sought a stay from this Court, which was denied on June 7, 1993.

and, until LOF obtains an accounting, the extent of Blue Cross' potential liability to the plan is unknown.

B. Facts.

The Group Health Insurance Plan is an employee welfare benefit plan under the Employee Retirement Income Security Act of 1974, 29 U.S.C. §§ 1001 *et seq.* ("ERISA"). The plan is, and since 1980 has been, self-insured in that claims are funded directly by the employer. Blue Cross administered claims under the plan from 1968 through 1987 under a Master Group Operating Agreement ("Contract"). From 1968 until 1980 benefits were provided through the purchase of insurance from Blue Cross. (R. 3: Amended Complaint ¶ 5; R. 36: Answer ¶ 5). In 1980, the Contract was amended. Under the amended Contract, Blue Cross continued to administer claims as it had done previously but was paid an administrative fee for its services. LOF was required to maintain a deposit with Blue Cross from which claims were paid. (R. 36: Blue Cross' Third-Party Complaint ¶ 8). The amount of the deposit represented approximately two months of claims and administrative fees and totaled from $2.5 to $5 million between 1980 and 1987. (R. 57: Kintner Affidavit ¶ 4). Blue Cross also billed LOF monthly for claims paid on behalf of the plan and for administrative fees. (*Id.*; R. 36: Third-Party Complaint ¶ 8).

The discretionary authority held by Blue Cross in administering claims under the plan was expressly governed by the specific terms of the Contract. Under the amended Contract, Blue Cross had discretion to develop written guidelines defining benefits and eligibility, to construe the terms of the plan, to grant or deny claims, and to resolve all disputes respecting benefits.[3] Blue

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3. Article III of the Contract reads in pertinent part:

> [Blue Cross] and Medical Indemnity will develop

(Cont'd)

Cross also had the authority to pay providers with funds advanced on behalf of the plan. (R. 57: Amendment to Master Group Operating Agreement at ¶¶ 3-4, Exhibit 2 to Kintner Affidavit).

Blue Cross has arrangements with various providers respecting amounts paid by Blue Cross to those providers for claims, including claims paid on behalf of the plan. It is now known and undisputed that Blue Cross received refunds from providers respecting amounts it had paid for claims, including amounts paid on behalf of the plan. It is also undisputed that Blue Cross retained these refunds and did not credit or reimburse the plan for any of the amounts. Blue Cross admitted these facts in its answer to the Amended Complaint. (R. 3: Amended Complaint ¶ 13; R. 36: Answer ¶ 13).

The Contract with Blue Cross was terminated effective December 31, 1987. After the relationship was terminated and before this lawsuit was filed, LOF demanded an accounting of any refunds Blue Cross received respecting amounts paid on behalf of the plan. Blue Cross refused to account for these refunds, which

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(Cont'd)

> written guidelines (an Administrative Manual) for the purpose of describing a uniform scope of benefits and defining eligibility requirements for Enrollees under this Agreement . . . .
>
> Any disputes which shall arise with respect to the right to service or with respect to benefits hereunder shall be submitted to and resolved by [Blue Cross] or Medical Indemnity, as the case may be, regardless of where the Enrollee shall reside.

(R.57: Article III, Amended Master Group Operating Agreement, Exhibits 1 and 2 to Kintner Affidavit).

were generated by Blue Cross using LOF plan funds. After the relationship with Blue Cross was terminated, LOF also learned that Blue Cross had improperly paid claims to nursing homes that were not covered by the plan. The extent of these improper payments is likewise unknown.

C. Proceedings Below.

LOF moved for partial summary judgment on its claims for an accounting and sought a ruling from the district court that Blue Cross was an ERISA fiduciary and had a duty to account to the plan on demand. The court denied LOF's motion and held that, in order to establish that Blue Cross was an ERISA fiduciary to the plan, LOF would have to prove that Blue Cross had the authority to prescribe the scope of benefits. (R. 86). The scope of benefits under the plan is prescribed by the employer and, in several instances, by collective bargaining agreements.

Because the trial court decision effectively eliminated LOF's primary cause of action and meant that LOF would have no claim under ERISA, LOF moved to dismiss the case without prejudice. Absent an accounting and the statutory relief provided under the ERISA, the case was rendered too costly to pursue. LOF, as plan administrator, sought the dismissal without prejudice so that the rights of participants or beneficiaries of the plan could not be adversely affected.

Blue Cross opposed the motion to dismiss and asked the trial court to dismiss the case with prejudice and to award Blue Cross its attorney fees. LOF vigorously opposed a dismissal with prejudice of its claims and any imposition of fees.

On November 25, 1991, the court issued an opinion stating that LOF's First, Second and Sixth Claims would be dismissed with prejudice and that the remaining claims would be dismissed

without prejudice but all references to ERISA in these claims stricken. (R. 111; Petitioner's Appendix at pp. 35a-37a). In the opinion, the court clarified its earlier summary judgment decision and held as a matter of law that Blue Cross was not a fiduciary to the plan and that LOF, as plan administrator, had no right to an accounting from Blue Cross. (*Id.* at p. 35a). The court gave LOF an opportunity to withdraw its motion, but made it clear that withdrawal would enable LOF to proceed with its pendent state law claims only and that the dismissal with prejudice of the ERISA claims and the claim for breach of common law fiduciary duties would remain the law of the case. (*Id.* at p. 36a). LOF did not withdraw its motion and judgment was entered. LOF timely appealed from the judgment dismissing its claims with prejudice.

REASONS FOR DENYING THE WRIT

There are no "special and important reasons" for this Court to grant petitioner discretionary review in this case. There is no constitutional question involved. There is no conflict among the circuits requiring resolution by this Court. There is no important question of federal law which has not been previously settled by this Court. The Court of Appeals for the Sixth Circuit simply applied well-established legal principles to the unique facts of this case and reached a result that Petitioner does not like. This is not a decision that warrants discretionary review by the United States Supreme Court.

The Court of Appeals held that Blue Cross is a fiduciary to the LOF plan respecting its claims administration and has a duty to account to the plan on demand for the matters at issue in this case. ERISA defines a fiduciary as anyone who "has any discretionary authority or discretionary responsibility in the administration of [a] plan." 29 U.S.C. § 1002(21)(A)(iii). The finding that Blue Cross is an ERISA fiduciary is based upon the authority held by Blue Cross under the express terms of the Contract and related plan

documents which are unique to this case. This Contract between these parties has since been terminated. There is no reason that this Court should accept discretionary review of a contract that has no real significance beyond the parties to this action and that no longer exists. The applicability to future situations is limited or non-existent, the Court of Appeals has already reviewed the specific Contract terms at issue, those terms are clear and unambiguous, and the authority held by Blue Cross is not seriously in dispute. The law is also well-settled that the authority to construe the terms of a plan and to grant or deny claims constitutes discretionary authority under ERISA.

The finding that, as an ERISA fiduciary, Blue Cross has a duty to account to the plan on demand is based upon well-established common law principles as incorporated into ERISA. A common law fiduciary has a duty to maintain records and to account to its principal on demand. *Restatement (Second) of Trusts* §§ 172-73; *Restatement (Second) of Agency* §§ 381-82. This Court has held that Congress invoked the common law of trusts to define the scope of duties of ERISA fiduciaries and has instructed the federal courts to "develop a federal common law of rights and obligations under ERISA-regulated plans." *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 110 (1989) (citation omitted); *Central States, Southeast & Southwest Areas Pension Fund v. Central Transport, Inc.*, 472 U.S. 559, 570 (1985). The decision in this case is consistent with the guidance provided in *Firestone* and *Central States* and there is no reason for this Court to review the decision.

By misstating the facts, Blue Cross tries to create a novel jurisdictional issue where none exists. Contrary to Petitioner's assertions at Issue I of its brief, LOF neither sought nor consented to the dismissal with prejudice of its primary cause of action. The dismissal with prejudice was entered solely at the insistence of Blue Cross. LOF strenuously opposed a dismissal with prejudice.

The judgment appealed from was both final and adverse within 28 U.S.C. § 1291. The procedural record was before the Court of Appeals and the jurisdictional question was fully presented there. The court correctly accepted jurisdiction consistent with established law. There is simply nothing novel in LOF's appeal from the final and adverse decision of the trial court below.

The Court of Appeals imposed no liability, fine, or sanctions upon anyone. It simply ruled that Blue Cross must account to the plan for its handling of the claims and money entrusted to it. Blue Cross would have this Court believe that the sky is falling as the result of the Court of Appeals' decision. The duty to account is integral to fiduciary status. The imposition of this duty upon a specific fiduciary in a specific case presents no special or important reason for the United States Supreme Court to grant a writ of certiorari.

I.

BLUE CROSS HAD DISCRETIONARY AUTHORITY IN ADMINISTERING CLAIMS UNDER THE PLAN AND IS A FIDUCIARY WITH RESPECT TO THE MATTERS AT ISSUE IN THIS LAWSUIT.

The contract gave Blue Cross the authority to develop written guidelines defining benefits and eligibility, to construe the terms of the plan, to grant or deny claims, to resolve all disputes respecting benefits, and to pay providers with funds advanced on behalf of the plan. Under ERISA, "a person is a fiduciary with respect to a plan to the extent . . . (iii) he has any discretionary authority or discretionary responsibility in the administration of such plan." 29 U.S.C. § 1002(21)(A)(iii).

The decision of the Court of Appeals holding that Blue Cross

is an ERISA fiduciary is based upon the statute and is consistent with other decisions addressing this question. *See, e.g., Reilly v. Blue Cross and Blue Shield United of Wisc.*, 846 F.2d 416 (7th Cir.), *cert. denied*, 488 U.S. 856 (1988) (Blue Cross was a fiduciary where it administered claims under a self-insured group health plan and received a fee for its services); *Blue Cross & Blue Shield of Alabama v. Weitz*, 913 F.2d 1544, 1545 (11th Cir. 1990) (As claims administrator of a self-insured plan, Blue Cross was a fiduciary under ERISA); *The Sixty-Five Security Plan v. Blue Cross and Blue Shield of New York*, 583 F. Supp. 380 (S.D.N.Y.), *reh. denied*, 588 F. Supp. 119 (S.D.N.Y. 1984) (Claims administration rendered Blue Cross an ERISA fiduciary).

Blue Cross does not deny that it is a fiduciary, rather Blue Cross says that it was somehow held to be a fiduciary respecting matters beyond the scope of its discretionary authority. (Petitioner's Issue II). Blue Cross was held to be a fiduciary respecting the matters at issue in this case. It had the authority to grant or deny claims and to pay providers. But for this authority, Blue Cross could not have received refunds relating to the amounts it paid and could not have improperly granted nursing home claims. Petitioner's concerns about hypothetical people in hypothetical situations should await a case involving such hypothetical circumstances — they provide no compelling reason to review this case.

II.

THE DECISION REQUIRING BLUE CROSS TO ACCOUNT FOR THE MATTERS AND FUNDS ENTRUSTED TO IT FOLLOWS THE DIRECTION PROVIDED BY THIS COURT AND PROVIDES NO BASIS FOR REVIEW.

The decision of the Sixth Circuit represents a routine application of legal principles established by this Court in numerous cases. This Court has specifically held that Congress intended to incorporate the common law of trusts in defining fiduciary duties under ERISA: "[R]ather than explicitly enumerating *all* of the powers and duties of trustees and other fiduciaries, Congress invoked the common law of trusts to define the general scope of their authority and responsibility." *Central States, Southeast & Southwest Areas Pension Fund v. Central Transport, Inc.*, 472 U.S. 559, 570 (1985). Consequently, this Court has instructed the lower federal courts to develop a federal common law of rights and obligations under ERISA-regulated plans consistent with the common law of trusts. *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 110 (1989) (citing *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 56 (1987)).

The decision of the Court of Appeals in this case follows the direction provided by this Court in *Central States, Firestone*, and *Pilot Life Ins. Co.* At common law, trustees and other fiduciaries have a duty to maintain records of their conduct and to account to their principal upon demand. *Restatement (Second) of Trusts* §§ 172-73; *Restatement (Second) of Agency* §§ 381-82. Since the common law of trusts defines the duties and responsibilities of ERISA fiduciaries, an ERISA fiduciary has a duty to account to the plan on demand just like his common law counterpart.

Blue Cross claims that the Court of Appeals has legislated a

new remedy under ERISA. This is not the case. The Court held that Blue Cross as an ERISA fiduciary had a *duty* to account to the plan on demand. The decision simply incorporates the common law of trusts in defining the duties and responsibilities of an ERISA fiduciary. The right of a principal to demand an accounting from a fiduciary is anything but a new remedy. ERISA provides remedies for breach of fiduciary duties. 29 U.S.C. § 1109. ERISA also provides a cause of action to enjoin violations of the statute or terms of the plan or "to obtain other appropriate equitable relief." 29 U.S.C. § 1132(a)(3). The Court of Appeals did not legislate a new remedy; it simply confirmed a duty long recognized and enforced by law. Remedies for breach of that duty are provided in ERISA.

Blue Cross also argues, as it did below, that before a plan may obtain an accounting from an ERISA fiduciary, it must prove a breach of fiduciary duty and damages. In other words, a plan may not obtain an accounting of the fiduciary's conduct unless it has already proved what the accounting would be expected to show. This is a catch-22 and, if Blue Cross' argument were the law, an ERISA fiduciary could insulate itself from liability simply by secret dealing.

The decision requiring Blue Cross to account to the plan for its administration of claims and for the funds entrusted to it is based upon well-established principles of law and the direction given by this Court. There is no reason to grant discretionary review of the decision.

III.

THERE IS NO *BONA FIDE* JURISDICTIONAL ISSUE IN THE CASE.

The judgment in this case disposed of all the claims and is final for purposes of 28 U.S.C. § 1291. 9 J. Moore, B. Ward & J. Lucas, *Moore's Federal Practice* ¶ 110.13(1) (1992). The judgment appealed from was also adverse to LOF.

Blue Cross tries to create a jurisdictional issue for review by misstating the facts. Petitioner's brief at Issue I implies that LOF sought and consented to a voluntary adverse judgment: "Whether litigants can bestow finality and appellate court jurisdiction on an interlocutory district court decision *by seeking and consenting to,* without reservation of any right to appeal, *a voluntary adverse dismissal* under Fed. R. Civ. P. 41(a)(2)?" (emphasis added). This issue has nothing to do with this case. LOF never sought or consented to the dismissal with prejudice entered by the district court in this case.

The procedural record was before the Court of Appeals and Blue Cross raised and argued this issue before that Court. The Court of Appeals correctly held that the case was appealable by LOF — finding that the motion to dismiss had to be read in light of the earlier adverse summary judgment decision that effectively eliminated LOF's primary claim. *Raceway Properties, Inc. v. Emprise Corp.*, 613 F.2d 656, 657 (6th Cir. 1980). *Raceway Properties* follows this Court's decision in *United States v. Procter & Gamble,* 356 U.S. 677 (1957). These cases hold that plaintiff may solicit a dismissal to facilitate review of an adverse ruling. The solicitation even of a dismissal with prejudice in these circumstances does not constitute consent to the adverse judgment. *United States v. Trifa,* 662 F.2d 447, 448 (6th Cir. 1981).

LOF sought a dismissal *without prejudice.* The dismissal entered was *with prejudice* at the insistence of Blue Cross. Contrary to Petitioner's assertions, LOF never agreed to a dismissal with prejudice and, indeed, vigorously opposed it. Nor did the district court ever ask LOF to agree. The district court simply allowed LOF the option of withdrawing its motion and proceeding to trial on the common law causes of action. LOF was not given any option respecting the disposition of the ERISA claims. The court made it clear that the ERISA claims were being eliminated on the merits regardless of any action by LOF. The only choice given was whether to withdraw the motion as to the remaining pendent state law claims.

An order which dismisses plaintiff's claims with prejudice is a final appealable order. *Smith-Bey v. Hospital Adm'r,* 841 F.2d 751, 755 (7th Cir. 1988); *Nichols v. Mobile Bd. of Realtors, Inc.,* 675 F.2d 671 (5th Cir. 1982). "[W]here the plaintiff moves to dismiss without prejudice, but the court dismisses with prejudice, the judgment is appealable by the plaintiff." 5 J. Moore, J. Lucas & J. Wicker, *Moore's Federal Practice,* ¶ 41.05[3] at pp. 41-72 (1991) (and cases cited therein); *Holiday Queen Land Corp. v. Baker,* 489 F.2d 1031 (5th Cir. 1974); *Garner v. Missouri-Pacific Lines,* 409 F.2d 6 (6th Cir. 1969).

Blue Cross says that in order to appeal, LOF had to reserve the right to do so and cites *Laczay v. Ross Adhesives,* 855 F.2d 351 (6th Cir. 1988), *cert. denied,* 489 U.S. 1014 (1989). *Laczay* concerned a stipulated dismissal with prejudice and is inapplicable here. Blue Cross made this same argument below in the same court that decided *Laczay* and it was rejected. Indeed, although the Court of Appeals cited *Laczay* in its opinion, Blue Cross' construction of that case was never discussed and was clearly not adopted. *Libbey-Owens-Ford v. Blue Cross & Blue Shield,* 982 F.2d 1031, 1034 (6th Cir. 1993).

There is no need for the Supreme Court to provide additional guidance respecting the application of 28 U.S.C. § 1291. As shown by the case law, the courts are applying well-established principles in resolving issues under § 1291. The outcome is determined by the specific circumstances of the case. In the present case, jurisdiction should not even be an issue. Blue Cross attempts to make it an issue by misstating the facts.

CONCLUSION

Based upon the foregoing, the Petition for a Writ of Certiorari should be denied.

Respectfully submitted,

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